Alaska Health Care Commission

Fraud & Abuse Findings & Recommendations

DRAFT 9-24-14 DRAFT

FINDINGS

1. Fraud and abuse prevention and investigation are important business practices and should be supported, but will not reform the health care system and will not address the major cost challenges. Realignment of fee structures, creation of more even negotiating fields, and evidence-based practice and coverage are the strategies required for reforming the system to address the major cost challenges.

2. CMS estimates 3-10% of Medicaid spending is fraud. Alaska Medicaid fraud recovery, while currently less than 1%, has significantly increased in recent years. Not reflected in the 1% recovery is the deterrent effect of the increased investigation and recovery effort.

3. Active collaboration between the Alaska Department of Law, the Alaska Department of Health & Social Services, the U.S. HHS Office of Inspector General, and U.S. Immigration & Customs Enforcement is resulting in significantly increased recoveries and convictions. Since October 2012 when the two State agencies ramped-up collaborative efforts to address Medicaid fraud:
   - Prosecutors presented charges in 93 criminal cases resulting in 62 convictions and saving a total of $12 million for the State of Alaska in the first year alone;
   - The Department of Law Medicaid Fraud Control Unit provided the Department of Health & Social Services Medicaid Integrity Program with information to suspend 7 agencies, and DHSS issued a total of 65 payment suspensions in SFY 2014 based on information from a variety of sources;
   - One large case involved investigating 53 individuals, with 35 convictions and $743,000 in savings;
   - The majority of cases have been home health or personal care attendant providers; and,
   - Another large case currently pending involves a single physician accused of fraudulently billing more than $1 million over the course of four years.

4. The Medicaid Fraud Control Unit currently has a backlog of cases that could be alleviated with additional staff support.

5. The State is sometimes unable to recover public funds lost through fraud. Requiring bonding and/or strengthening state seizure law could increase the State's ability to recover funds found to be paid for fraudulent claims.

6. The new Medicaid Recovery Audit Contractor (RAC) Audit program required by CMS under the Affordable Care Act is not working in Alaska. Alaska's Medicaid RAC contractor recently suspended performance of audits under their contract because they were not able to generate income in our state due to the difficulty with aligning the DRG payment focus of the RAC audit process with Alaska's fee-for-service payment structures.

7. State audits performed by Myers & Stauffer under AS 7.05.200 do not generally identify criminal activity, but one recently identified fraud case will result in $1 million savings for the State. These audits have identified over $5 million in overpayments since October, 2012, so this program is beneficial.

8. Fraudulent providers are exploiting vulnerabilities in the system.
    - Recipients have no financial incentives to provide a check on potential fraudulent practice by their providers, and also do not receive an Explanation of Benefits statement as a patient on private insurance does and so cannot verify services billed on their behalf.
    - Lack of enrollment of some rendering provider types creates avenues for fraudulent providers caught under one provider type to continue billing for services under another provider type.

9. Abuse of prescription opioid narcotics is not only a critical health concern, as documented by the Alaska Health Care Commission in 2013, but is also a significant source of fraud and abuse in the health care system. Alaska's current Prescription Drug Monitoring law creates barriers that restrict the Department of Law and the Department of Health & Social Services from accessing the data and using it to identify potentially fraudulent or abusive prescribing practices and doctor-shopping by patients.

RECOMMENDATIONS

I. The Alaska Health Care Commission recommends the Commissioner of the Department of Health & Social Services increase efforts to address fraud in the Medicaid program and streamline audit processes for providers by:
    a) Establishing regulations to enroll all rendering provider types as Medicaid providers.
    b) Repurposing discretionary audits performed by Myers & Stauffer under AS 7.05.200 to target provider types that pose the greatest risk of overpayment, and to relieve providers who demonstrate compliance.
    c) Implementing procedures to reduce the cycle time from audit notification to providers through final report issuance, and to improve communication with providers so that they have on-line access to information on the status of audits.
    d) Providing Explanation of Benefits statements to Medicaid recipients, with education about their obligation to notify the department in the event of a statement of payment for services they did not receive.
    e) Requesting a waiver from CMS from the Medicaid Recovery Audit Contractor program requirement established under the Affordable Care Act.

II. The Alaska Health Care Commission recommends the Commissioner of the Department of Health & Social Services and the State Attorney General continue to strengthen coordination and collaboration between the Medicaid Fraud Control Unit, the Medicaid Integrity Program, DHSS Medicaid operating divisions, and federal fraud investigation and control programs.

III. The Alaska Health Care Commission recommends the legislature fund and the Governor support expanded capacity in the Department of Law Medicaid Fraud Control Unit to investigate and prosecute criminal fraud cases.

IV. The Alaska Health Care Commission recommends the legislature:

a) Strengthen state seizure laws, and consider bonding requirements for certain high-risk Medicaid providers, to increase recovery of Medicaid funds lost to fraud.
b) Provide the Medicaid program the authority to adjust future payments to providers who have past-due obligations to the program.
c) Remove statutory barriers to Department of Health & Social Services and Department of Law access to and use of the Prescription Drug Database for fraud identification and statewide drug abuse prevention efforts.
d) Create a more robust prescription drug control program by ensuring financial support to continue the program, and supporting upgrade of the database to real-time functionality to identify and prevent doctor-shopping practices.

V. The Alaska Health Care Commission recommends the Commissioner of the Department of Health & Social Services continue efforts to increase medical management to address waste in the Medicaid program, such as through:

a) Expansion of prior authorization requirements for medical necessity for services, and establishment of user-friendly and efficient prior authorization processes for providers.
b) Establishing pre-payment review for providers who have billed for services inappropriately in the past, and providing education and technical assistance to assist providers with learning proper billing practices.
c) Streamlining Service Utilization Review procedures to target information gathering to outlying procedures, and discontinue the burdensome practice of requiring all patient data when an outlying procedure is identified.
d) Implementing a care coordination program for beneficiaries who over-utilize emergency room services.
e) Tightening review of Medicaid travel for compliance with program requirements.
f) Investigating beneficiaries who pay cash for prescriptions for controlled substances, potentially with the intent of making the purchase more difficult to track, to ensure the drugs were not diverted for improper or illegal use.
g) Implementing electronic verification of Personal Care Assistant and Waiver services.